State of Rhode Island and Providence Plantations

DEPARTMENT OF HUMAN SERVICES
Office of the Director

April 16, 2002

Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Subject: Request for Extension of the RIte Care Waiver

Dear Mr. Scully:

The State of Rhode Island hereby requests extension of its Section 1115 waiver for RIte Care (Project No. 11-W-004/1-01) until July 31, 2005. This request is submitted in conformance with the Centers for Medicare & Medicaid (CMS) outline for a Section 1115 waiver extension, as follows:

- State assurances
- Evidence that the State addressed "State Notice Procedures" published in the *Federal Register* on September 27, 1994 and consulted with Federally-recognized tribes

Should you have any questions concerning this request, please do not hesitate to contact Tricia Leddy at (401) 462-2127 or TriciaL@gw.dhs.state.ri.us.

We look forward to CMS' earliest possible, favorable response to this request.

Sincerely,

Jane Hayward , Director

Cc: T. Leddy
R. Pecorella
A. Adamo
R. Preston

REQUEST FOR EXTENSION OF THE RITE CARE WAIVER: PROJECT NO. 11-W-004/1-01

Submitted to:

Center for Medicaid and State Operations
Centers for Medicare & Medicaid
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted by:

Department of Human Services
State of Rhode Island and Providence Plantations
600 New London Avenue
Cranston, RI 02920

April 2002

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A. BACKGROUND AND OVERVIEW

The Rhode Island RIte Care project is a Statewide initiative that seeks to increase access to, and the delivery of, primary and preventive health care services for all Family Independence Program (FIP) recipients, certain low-income children and their families, and pregnant women through a fully-capitated managed care delivery system. Important project dates include:

- **Initial Waiver Application Submitted:** July 20, 1993
- **Application Approved:** November 1, 1993
- **Demonstration Project Implemented:** August 1, 1994
- **Waiver Extension Request Submitted:** March 17, 1998
- **Waiver Extension Request Approved:** September 17, 1998
- **Waiver Extension Expires:** July 31, 2002

Over the years, RIte Care has continued to evolve in response to the State's experience in operating the program and as a result of national and state policy initiatives.

The most significant change in the project has been the increase in the number of populations eligible for RIte Care. Initially, RIte Care covered FIP recipients and the following expansion populations:

- Children up to age 6 with income up to 250 percent of the Federal Poverty Level (FPL)
- Pregnant women with income up to 250 percent of the FPL
- Pregnant women with income from 250 and 350 percent of the FPL (State-funded only)

- *April 1996* – Since then, eligibility for coverage under the RIte Care waiver has been expanded to children from age 6 to age 8 with income up to 250 percent of the FPL
- *May 1997* – Children age 8 up to 18 with income to 250 percent of the FPL
- *January 1998* – Although already covered, submission and approval of a SCHIP State Plan gave the state the higher Title XXI Federal matching rate for this population. It should be noted that the actual effective date for SCHIP implementation was October 1, 1997.

- *October 1998* – Implemented a streamlined mail-in application, application with minimal documentation requirements and eliminated face-to-face requirements to confirm eligibility.

- *November 1998* – Parents and guardians of children enrolled in RIte Care with income up to 185 percent of the FPL through a Section 1931 State Plan Amendment (SPA).

- *June 1999* – Children up to their 19th birthday with income up to 250 percent FPL via Title XXI SPA expansion and undocumented non-citizen children in a state-funded program.

- *April 1999* – RIte Care enrollment outreach project begins, encompassing school-based outreach combined with contracts with 32 community-based organizations using performance based incentives for locating and enrolling eligible children.

- *June 2000* – RIte Care enrollment outreach project ends

- *August 2000* – Submitted a Section 1115 waiver amendment to include a six-month waiting period and cost-sharing for expansion groups

- *December 2000* – Foster children begin to transfer from fee-for-service Medicaid to RIte Care

- *January 2001* – HCFA acts to approve the SCHIP waiver request to cover parents and guardians of children between 100 and 185 percent of the FPL enrolled in RIte Care and pregnant women between 185 and 250 percent of the FPL

- *February 2001* – RIte Share, premium assistance program based on employer sponsored insurance that pays the employee share of premiums, begins voluntary enrollment

- *M*ay *2001* – Resubmitted modified Section 1115 waiver amendment to move section 1931/SCHIP waiver parents who are between 110 and 185 percent FPL into the 1115 Medicaid waiver as an 1115 SCHIP expansion group; also to allow a six month waiting period and cost sharing groups for expansion.

- *September 2001* – HCFA acts to approve waiting periods and cost sharing for expansion groups and moved section 1931/SCHIP waiver parents who are between 110 and 185 percent FPL into the 1115 Medicaid waiver as an 1115 SCHIP expansion group

- *January 2002* – Monthly premiums are implemented at up to 3 percent of income for expansion enrollees over 150 percent FPL.

- *February 2002* – RIte Share mandatory enrollment of eligibles with access to qualified employer sponsored health insurance begins.

Appendix B details the changes to the original RIte Care program resulting in the eligibility expansions that have contributed to the low rate of uninsured Rhode Islanders today. Indeed, according to the September 2001 CPI report, the rate of insured children in the State is about 2 percent and the overall insurance rate at 92 percent.

B. STATE ASSURANCES

This chapter of this waiver extension request provides State assurances in the following areas:

- Program Objectives
- Special Terms and Conditions
- Project Monitoring and Outcomes
- Budget Neutrality

State assurances related to each is discussed in a separate section below.

I PROGRAM OBJECTIVES

The purpose of RIte Care was to assure the availability of health care for families participating in Rhode Island's Medical Assistance Program on the basis of eligibility through FIP[1], FIP-related, or Medically Needy criteria, as well as to the pregnant women and children without health insurance newly eligible under the waiver. RIte Care is intended to increase access to primary care, improve the continuity and quality of care, and control the rate of growth in Medical Assistance program expenditures for this population.

The RIte Care program accomplishments in terms of these goals may be summarized as follows:

Member Choice of Health Plan

- Enrolled 117,000 members into one of three health plans through January 31, 2002. Originally, there were two additional health plans (both licensed health maintenance organizations, or HMO), participating in RIte Care: Harvard Community Health Plan and Pilgrim Health Care. The two plans merged to become Harvard Pilgrim Health Care of New England (HPHCNE) in 1995. HPHCNE left the Rhode Island market in 1999.

- More than 90 percent of enrollees chose their own health plan.

- Only 4 percent changed Health Plans when given the opportunity to do so during the first open enrollment period; only 1 percent changed plans during the second open enrollment period and only 3 percent during the third open enrollment period. In subsequent periods, those switching plans have averaged less than 3 percent or less during open enrollment.

[1] Under the welfare reform initiative in Rhode Island, Temporary Assistance to Needy Families (TANF) is known as the Family Independence Program (FIP).

Covered Uninsured Families

- Made comprehensive health coverage available on August 1, 1994, to previously uninsured pregnant/postpartum women uninsured children up to age six, up to 250 percent of the Federal Poverty Level (FPL). Coverage for uninsured pregnant/postpartum women between 250 and 350 percent of the FPL was also provided at State cost with monthly enrollee premium.

- Made coverage available on March 1, 1996, to uninsured children up to age eight in families up to 250 percent of the FPL.

- Made coverage available on May 1, 1997, to uninsured children up to age 18 in families up to 250 percent of the FPL.

- Made coverage available on January 1, 1997, to licensed family child care providers and their families at State cost.

- Made coverage available on November 1, 1998 to parents and guardians of children enrolled in RIte Care up to 185 percent of the FPL.

- Made coverage available on June 1999 to cover children up to their 19th birthday.

- Made a premium assistance program, RIte Share, available on February 1, 2001 to help low- and moderate-income families obtain health insurance through their employers.

- Reduced uninsurance in Rhode Island, according to the most recent *Current Population Survey*, to 6.2 percent overall and **2.4 percent for children**. Rhode Island is now the state with the lowest uninsurance rate in the entire nation both for the population overall and for children.

Improved Access to Primary Care

- Increased primary care physician participation in Medicaid from 350 physicians pre-RIte Care to over 900 physicians post-RIte Care.

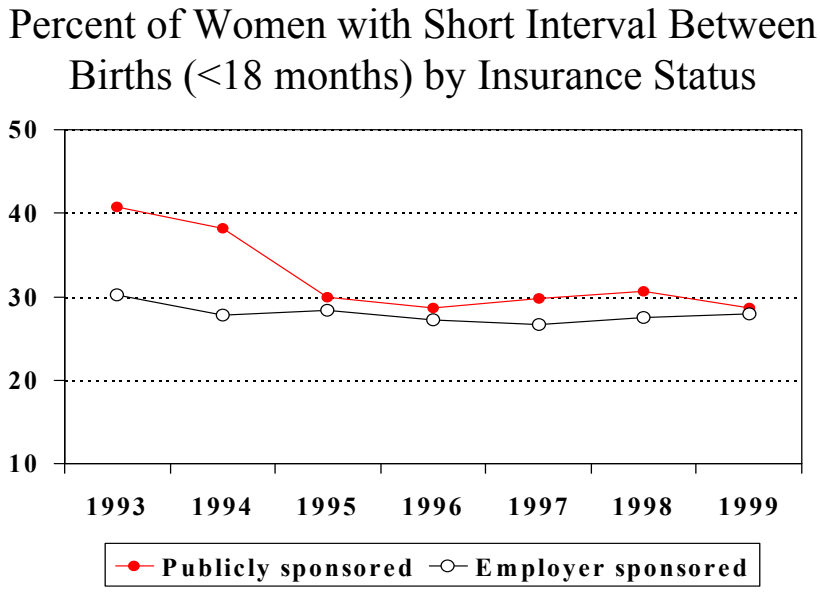
- Increased average per enrollee physician visits from two per year pre-RIte Care (1993) to four and one half per year from 1997 through 2000. It should be noted that visits to health care specialists have averaged 1 to 2 per enrollee per year.

- Decreased emergency room (ER) visits and hospital utilization by more than one third from 1993 to 2000. ER visits, which were 750/1000 pre RIte Care, peaked at about 450 per 1,000 in early State Fiscal Year 2000 and appears to be leveling off at 420 per 1,000.

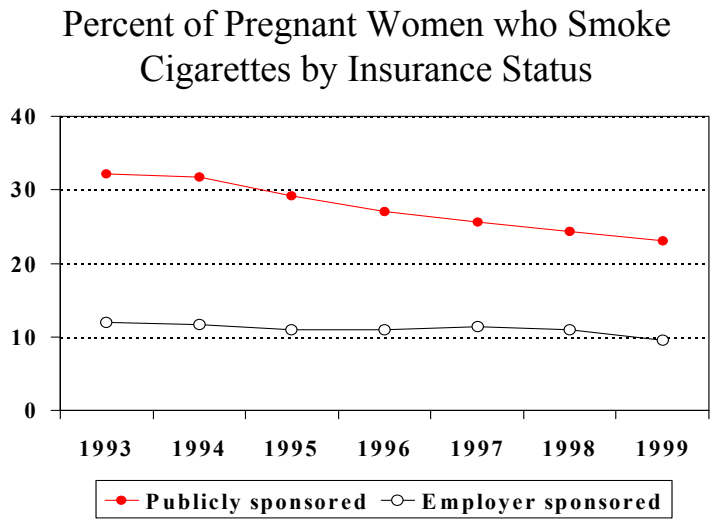
- Majority of RIte Care enrollees report that care is accessible in annual satisfaction surveys.

Positive Impact on Maternal Health

- Increased the number of women on Medicaid waiting at least 18 months between births from 58 percent of pre-RIte Care (1993) to 72 percent post-RIte Care (1999). This virtually closed the gap between Medicaid and commercially-insured women on this issue.



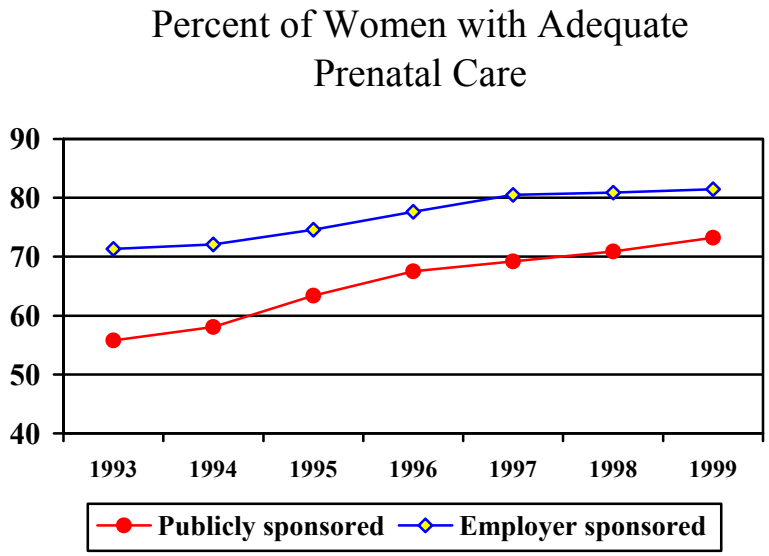
- The percentage of pregnant women on Medicaid who smoked during pregnancy decreased significantly from 33 percent to 22 percent in 1999.



Improved Prenatal Care

- The number of women on Medicaid who began prenatal care in the first trimester increased significantly from 76 percent in 1993 to 84 percent in 1999.

- The number of women on Medicaid receiving adequate prenatal care increased significantly from 55 percent in 1993 to 73 percent in 1999.



Improved Infant Health Outcomes

- The number of low birth weight infants born to Medicaid enrolled mothers in a matched birth cohort in "very low poverty" inner city tracts decreased from 10.1 percent in 1993 to 5.1 percent in 1995, again showing a positive trend.

- In the same inner city birth study of pre and post RIte Care births, the percentage of infants who had their first physician visit before two weeks increased significantly from 54.4 percent in 1993 to 70 percent in 1995.

- In this same study, the percentage of infants who waited less than two weeks for specialty care increased significantly from 43.5 percent in 1993 to 71.4 percent in 1995.

- As will be shown later in this Waiver extension request, these results have been achieved while maintaining very high member satisfaction and containing costs.

Legislation - as noted in Chapter A, the State has taken advantage of SCHIP to expand RIte Care and increase the FMAP. In addition, the RIte Care Health Plan Contract was amended June 21, 2001 to incorporate provisions of the Balanced Budget Act (BBA)

Health Plan Contractual Provisions

In order to conform to provisions of the federal Balanced Budget Act (BBA), the RIte Care Health Plan Contract was amended in June 2001 to include:

- **Emergency Services** – Incorporation of "prudent layperson" as basis for determining scope of services covered.

- **Health Insurance Portability and Accountability Act (HIPAA)** – Requirement that health plans comply with "national electronic standards for automated transfer of certain health care data" as well as other provisions of HIPAA.

- **Post-Stabilization** – Definition of post-stabilization services and coverage requirement.

- **Stabilized** – Definition of "stabilized".

- **Automatic Assignment to Health Plans** – Language requiring "preserving physician-patient relationship" when making health plan assignments.

- **Health Plan Marketing** – Prohibitions related to health plan marketing.

- **Required Information** – Information that must be disclosed "during open enrollment."

- **Reasons for Disenrollment** – Language permitting a member to disenroll "without cause" during the 90 days following the effective date of the individual's initial enrollment.

- **Enrollee Provider Communication** – Provider right to "freely advise" patients.

- **Second Opinion** – Entitlement to a second opinion for members.

- **Provider Discrimination** – Prohibition on provider discrimination.

- **Access for Women** – Direct access to a women's health specialist.

- **Initial Assessments** – Added BBA-required language.

- **Annual Notification** – Members right to request and obtain specific information.

- **Cultural Competence** – Added BBA-required language.

- **Physician Incentive Plan** – Added language referencing 42 CFR 422.08 and 210, 434.67, 434.70 and 1003.

Also included along with these changes was an extension of the contract term until December 31, 2004.

II. SPECIAL TERMS AND CONDITIONS

The State's compliance with the Special Terms and Conditions identified in the approved waiver, effective September 1, 2001, is as follows:

Plan Contracting

- Received prior approval from CMS for each of contract amendments the June 21, 2001 revisions noted above.

- Physician capacity continues to be monitored through the mainstream clause in the health plan contract, the member satisfaction survey, and the encounter data system.

- Medicaid disclosure requirements of 42 CFR 455, subpart B are fully met.

- All health plans providing RIte Care services under state contracts are state licensed health maintenance organizations.

- Contract with ACS/Birch & Davis has been maintained for assistance in managing the operational and administrative aspects of the program.

Federally Qualified Health Centers (FQHCs)

- The FQHCs in the State formed their own health plan – Neighborhood Health Plan of Rhode Island (NHPRI). In addition, United HealthCare of New England and Coordinated Health Partners (Blue CHiP) contract with Federally Qualified Health Centers.

- Since RIte Care began, the State has had in place a system for making transition payments to the FQHCs. Each FQHC is paid a fixed fee per month for each member who selects a FQHC the primary care provider. Payments are made through the Rhode Island Community Health Center Association. Aggregate expenditures for these transition payments do not exceed $5.5 million annually and are included in budget neutrality calculations.

- The State has risk share arrangement with NHPRI that began in July 1, 1996. The provisions of this arrangement are incorporated into the State's contract with NHPRI and were approved by CMS. A similar risk share arrangement was made

with Blue CHiP for the contract period beginning in June 2001. Costs under this arrangement are included in budget neutrality calculations.

Institutions for Mental Disease (IMDs) – Butler Hospital is the only IMD reimbursed by the health plans for RIte Care enrollees aged 22 to 64.

Eligibility – The State considers each member of the family unit (including any Medicaid-eligible members) for purposes of determining countable income.

Cost-Sharing and Waiting Period Plan – In September, CMS approved waiting periods and cost sharing for expansion groups and moved Section 1931 / SCHIP parents with income between 110 and 185 percent of the FPL into the 1115 Medicaid waiver as an 1115 SCHIP expansion group. In January of 2002, monthly premiums were implemented at up to 3 percent of income for expansion enrollees over 150 percent FPL.

Pregnant Undocumented Non-Citizens – Pregnant undocumented non-citizens are covered through a state-funded only expansion under RIte Care are only covered for emergency services where Federal cost-sharing is involved. Other services are reimbursed with 100 percent State funds.

Family Planning Services – The State continues to provide CMS with analysis of percent of capitation rate. Adjustments in Federal funds are made accordingly. The State intends to continue its discussions with CMS to include an appropriate allocation of the capitation rate for primary care for women aged 15-44 as a family planning service in accordance with the intent of the Terms and Conditions.

Encounter Data Requirements

- All Health Plans are submitting encounter data on a regularly scheduled basis. Once data are received, they are edited and "cleaned" as necessary. Data undergo ongoing verification. Encounter data are now being used to produce *RIte Stats,* a monthly newsletter, as well as analyses of specific utilization and cost estimates for the enrolled population (see Attachment A).

- The encounter data system produces standard reports on multiple measures. However, the State does not rely solely on these reports. A separate study of childhood immunization levels and lead screening was conducted in conjunction with the Brown University Medical School. As noted in Section A5 of this waiver extension request, MCH Evaluation has conducted a Prenatal Care and Birth Outcome Study and an Infant Health Survey. In addition, a neonatal intensive care unit (NICU), emergency room (ER) and behavioral health utilization were each the subject of clinical focused studies performed by the State's external quality review organization contractor. Pediatric asthma has also been established as one of the performance goals as part of the State's incentive-based performance system.

Quality Assurance Requirements

- The State developed a methodology to monitor the performance of the health plans, which is incorporated into the *Plan for Monitoring RIte Care Health Plans* submitted previously to CMS. The State has a contracted with Island Peer Review organization (IPRO), to serve as the State's external quality review organization (EQRO) contractor, and will be issuing a new request for proposals for EQRO services.

- Out-of-plan utilization is assessed quarterly through ad hoc reports from the MMIS. Use of emergency room services was the subject of a clinical focused study on access to emergency and urgent care conducted in conjunction with the annual Member Satisfaction Survey. Waiting time and access to specialty providers are part of the annual Member Satisfaction Survey. A general "Access Study" and a "Behavioral Health Access Study" have been performed. Client satisfaction is measured through the annual Member Satisfaction Survey, and through analysis of complaints, grievances, and appeals.

- Since enrollment began, complaint and grievance data are collected from the health plans and analyzed quarterly.

- Calls to the State's Info-Line are collected and analyzed to determine member problems / concerns related to the health plans and access to specific services.

- The health plans are obligated by contract to perform at least three clinical focused studies per year.

- In-plan utilization is monitored through the Encounter Data System.

- Health Plans are required under State regulation to meet National Committee of Quality Assurance (NCQA) standards. Two of the three participating health plans have been rated as "Excellent" by NCQA.

Guidelines for State Monitoring of Plans

- Section 2.12.03.01 of the RIte Care Health Plan contract addresses this requirement.

- The *Plan for Monitoring RIte Care Health Plans*, previously submitted to CMS, delineates the State's monitoring approach.

Financial reporting and general administrative reporting requirements have been fully met as well. Budget neutrality is addressed later in this waiver extension request.

III. MONITORED AND DEMONSTRATED

This section of the waiver extension request addresses:

- Member satisfaction;
- Quality of care;
- Adequacy of service delivery system; and
- Adequacy of financial management

3.1 Member Satisfaction

The first RIte Care Member Satisfaction Survey was conducted in 1996 using a random sample of 3,356 RIte Care members stratified by health plan membership to ensure adequate representation. The sample was designed to have a margin of error of plus or minus 5 percent.

The survey instrument, developed in collaboration with the RIte Care Consumer Advisory Council, underwent extensive pre-testing and its final form covered the following areas:

- Primary care provider services;
- Specialty services;
- Pharmacy;
- Emergency services

Questions in each area were designed to obtain information on such elements as waiting times for appointments, call back times by physicians (or staff), ability to obtain specialty referrals, convenience in having prescriptions filled, and ability to obtain emergency services. Both versions were in English and Spanish.

3.2 Quality of Care

The RIte Care Member Satisfaction Survey has been completed every year since 1996. The latest versions completed for State Fiscal Year 2001 was mailed to 4,650 members and had a 33 percent response rate. The highlights of this survey are shown below:

- Satisfaction levels did not vary by speaking language or who was covered (parent vs. child only) and was consistent with overall satisfaction levels in the three previous years. Overall, more than 96 percent of respondents reported that they

were either very satisfied or satisfied with RIte Care. This compares favorably to the previous three years, when the range was on average 96 percent.

- Over 97 percent of Spanish-speaking respondents reported they were either very satisfied or satisfied with the RIte Care program.

- Survey responses indicated that about 97 percent of respondents very satisfied or satisfied with RIte Care.

- Almost 92 percent of respondents rated their own health or their child's overall health as either excellent, very good, or good. Ninety-six percent of adults responding on behalf of their children rated their child's overall health excellent, very good, or good. Adult and Spanish-speaking respondents rated their overall health lower, 84 and 81 respectively.

- About 92 percent of survey respondents had seen their regular doctor for care in the 12-month prior to completing the survey. This figure represents a two percent increase over the previous three years.

- Over 93 percent of survey respondents reported having a regular doctor. This figure was 91 percent last year and 86 percent in the 1999 survey report.

- About 96 percent of respondents answering on behalf of RIte Care children indicated the child had a regular doctor.

- Eighty-five percent of respondents stated they usually talk to their regular doctor when sick or seeking medical advice. The previous year it was 90 percent.

- Over 96 percent of respondents were very satisfied or satisfied with the services of their regular doctor. This percentage is comparable to the previous four years.

- Over 96 percent of respondents indicated they were very satisfied or satisfied with the amount of time their regular doctor spent with them. This high level of satisfaction has been consistent for the five years the RIte Care member satisfaction survey has been conducted.

- About 73 percent of survey respondents reported that their appointments began on time or within 30 minutes of the scheduled time. This figure is about the same as the previous year.

- About 71 percent of respondents indicated they saw their doctor the same day when they called for an appointment when sick, compared to 73 percent last year and 76 percent two years ago.

- Over 96 percent of respondents were very satisfied or satisfied with their regular doctor's explanations of their health problems or treatments needed.

- About 87 percent of respondents were very satisfied or satisfied with reaching their regular doctor evenings, nights, weekends, and holidays. The previous year it was 90 percent.

- Ninety-four percent of respondents were very satisfied or satisfied with getting a referral to a specialist.

- Ninety-two percent of respondents reported they did not have any problems getting prescriptions filled.

- Seventy-nine percent of respondents indicated they were very satisfied or satisfied with their emergency room treatment. Last year, it was 84 percent

- About 87 percent of respondents reported that they found their Health Plan's staff very helpful or helpful, compared to 90 percent last year and 91 percent two years ago.

- Ninety-two percent of respondents reported that they have never been denied services by their RIte Care Health Plan.

- About 55 percent of respondents reported that they know they could appeal decisions about payment for services by their Health Plan.

- About 30 percent of respondents indicated that they are aware they are welcome to attend the monthly meetings of the Consumer Advisory Committee.

- For adults responding on behalf of their children:

  - Sixty percent indicated that in the last twelve months their child's regular doctor talked to them about accident prevention, e.g., bike helmets, seat belts, or car seat use.

  - Twenty-four percent indicated that their child's regular doctor talked to them about mental health issues such as depression.

  - About forty-one percent reported that in the last twelve months their child's regular doctor talked to them about parenting issues such as growth and parenting skills.

- Sixty-five percent of adults responding for themselves indicated that their regular doctor had talked to them about lifestyle issues that affect health such as diet, exercise, seat belt or car seat use.

- About 52 percent of adults answering on behalf of themselves indicated that their regular doctor talked to them about mental health issues such as stress, depression or anxiety.

- About 35 percent of adults answering for themselves reported that their regular doctor talked to them about family planning issues such as birth control or prenatal care.

- About 55 percent of respondents who felt the translation assistance benefit was applicable to them were offered the assistance by their doctor or Health Plan. It was 67 percent the previous year.

- About 94 percent of respondents were very satisfied or satisfied with RIte Care's transportation benefit.

The survey results are highly gratifying to the State. RIte Care is realizing its intended objectives not only as a matter of fact, but also as a matter of member opinion.

3.3 Adequacy of Service Delivery Network

The State monitors the adequacy of the service delivery system on a continuous basis. Provider network listings are updated monthly and these listings are matched as necessary with enrollee/ applicant listings to assess any network gaps in primary care provider (PCP) availability. Geo-access analyses have also been performed.

The various analyses demonstrate clearly that there is sufficient provider capacity available for not only current enrollment levels but to accommodate ongoing expansion. As was noted earlier in this waiver extension request, PCP capacity has increased from approximately 350 physicians under the Medicaid fee-for-service system to over 900 under RIte Care. This participation represents in excess of 90 percent of the practicing PCPs in the State. In addition, most specialists in the State participate in RIte Care.

The State has performed special analyses concerning access to care. The following highlights some of the key findings from several of these analyses:

1. *Behavioral Health Care Access Study* – This study was completed and submitted to CMS in 1998 and included intensive, on-site review of health plan compliance with behavioral health contract provisions established to address concerns related to provider specialization and the multiethnic, multilingual nature of the enrolled RIte Care population.

   Highlights of the behavioral health special analysis findings were as follows:

   - Participating Health Plans are accredited by the National Committee for Quality Assurance.

   - All Health Plans have well-defined intake processes and appropriate appointment access standards.

- All Health Plans coordinate in- and out-of-plan benefits.

- All Health Plans assign complex cases to intensive case management.

- Provider networks meet all statutory and contractual requirements, and all Health Plans have a credentialing exceptions policy and/or use out-of-network providers on a case-by-case basis.

- Areas for improvement include:

  – Access for non-English speaking enrollees

  – Access for child sexual abuse evaluations

2. *Prenatal Care and Birth Outcomes Study* –This study was based upon data through 1995 and reported in *RIte Care Program Quarterly Report: October 1996 through December 1996*, show:

   - Early entry into prenatal care for pregnant Medicaid women, i.e., in the first trimester, *improved significantly* from 76 percent in 1993 (pre-RIte Care) to 82 percent in 1995 (RIte Care). Although a gap between Medicaid population and the privately insured population persists, the gap was cut in half from 1993 to 1995.

   - Adequacy of prenatal care, as measured by the Kotelchuck Adequacy of Prenatal Care Index, *improved significantly* for pregnant Medicaid women, from 55 percent in 1993 (pre-RIte Care) to 65 percent in 1995 (RIte Care). Inadequate prenatal care *declined* by 40 percent during the same time period. Once again, although the gap between the Medicaid population and the privately insured population persists, it was cut by 55 percent from 1993 to 1995.

   - Maternal smoking, the most important, modifiable risk factor associated of low birth weight and infant death, *declined* by 14 percent for pregnant Medicaid women from 1993 (pre-RIte Care) to 1995 (RIte Care).

   - Short interbirth interval, i.e., less than 18 months, associated with low birth weight, *declined* by 34 percent for Medicaid mothers from 1993 (pre-RIte Care) to 1995 (RIte Care).

   - The percentage of low birth weight Medicaid babies, the major determinant of infant health, *decreased* by 7 percent from 1993 (pre-RIte Care) to 1995 (RIte Care).

   - The percentage of premature Medicaid births *decreased* by 8 percent from 1993 (pre-RIte Care) to 1995 (RIte Care).

During the last quarter of 1997, this analysis was repeated for the 1996 birth file. The findings analysis showed that positive trends on the access and adequacy of prenatal care, maternal health status and newborn health status related to RIte Care continued to hold:

- **Access to prenatal care** - Early entry into prenatal care for pregnant Medicaid women from 78 percent in the pre-RIte Care time period to 82 percent in 1999.

- **Adequacy of prenatal care -** Adequacy of prenatal care improved significantly for pregnant Medicaid women, from 57 percent in the pre-RIte Care time period to 71 percent in 1999. Inadequate prenatal care declined significantly by 39 percent during the same time period.

- **Maternal smoking -** Maternal smoking **declined** by 28 percent for pregnant women from the pre-RIte Care time period to 1999.

- **Short interbirth interval** - Short interbirth interval **declined** by 30 percent for Medicaid mothers from the pre-RIte Care time period to 1999.

- **Low birth weight babies** – The percentage of low birth weight Medicaid babies **decreased** by 6 percent from the pre-RIte Care time period to 1999.

- A report presenting the finding of the study update was forwarded to CMS when it was completed.

3. *Infant Health Survey* – This survey was conducted to assess the impact of RIte Care on access to and the quality of pediatric primary care in an inner city high-risk population. The study was initiated prior to individuals enrolling in RIte Care health plans, so that the effects of RIte Care could be clearly discerned. Specifically, the sample for this study involved two inner city birth cohorts. The first, 1993 Cohort (i.e. pre-RIte Care), consisted of all resident births for Providence inner city census tracts 1 through 7, 12 through 14, 19 and 26 that occurred from March 1, 1993 through July 30, 1993. The second, 1995 Cohort (i.e. post-RIte Care), consisted of all inner city births from the same census tracts and born from March 1, 1995 through July 30, 1995. The 1993 Cohort consisted of 588 births and the 1995 Cohort consisted of 475 births.

   Face-to-face interviews were conducted with mothers when the infants were one year old. Information was collected on entry into primary care and the number of primary and acute care visits, EPSDT visits, up-to-date on immunizations, specialty care, emergency department visits, hospitalizations, barriers to care and satisfaction with care in the infant's first year of life. Data sources were linked and included the birth certificate file, mother interview and pediatric medical record.

   Medicaid infants comprised 75 percent of the 1993 Cohort and 709 percent of the 1995 Cohort. The response rate in 1993 was 58.3 (343/588) and the response rate in 1995 was 70.5 percent (335/475).

The major findings from the study after RIte Care was implemented on the following measures:

- In 1993, 54 percent of inner city infants had their first physician visit at or before two weeks. In 1995, this percentage rose to 70 percent.

- In 1993, 85 percent of inner city infants had five or more pediatric preventative visits in the first year of life. In 1995, the percentage rose to 88 percent.

- In 1993, 88 percent of inner city infants were up-to-date on their immunizations. In 1995, this percentage rose to 95 percent. There were statistically significant improvements in the following EPSDT services: physical examination, height/weight, vision screening, and anemia screening.

- In 1993, 19 percent of the infants were referred to specialty care by their primary care provider (n=65) and 44 of these infants were seen within two weeks for a specialty care appointment. In 1995, 28 percent of the infants were referred to specialty care (n=93), and 71.4 percent were seen within two weeks for a specialty care appointment.

- In 1993, 61.7 percent of the infants were treated in the emergency department. In 1995, the rate was 59.7 percent. In 1993, the emergency department visit rate was 163.6 per 100 infants. In 1995, this rate decreased to 137.5 visits per 100 infants.

- In 1993, 20.1 percent of the infants were admitted to a hospital. In 1995, 19.1 percent were admitted to a hospital. In 1993, the average length of stay was 5.7 days. In 1995, the average length of stay decreased to 4.2 days.

- In 1993, 19.6 percent of mothers reported that a lack of transportation stopped them form obtaining primary care for their infant. In 1995, this percentage decreased to 13.4 percent. In 1993, 14 percent of mothers reported that an inability to find childcare for other children stopped them from obtaining primary care for that infant. IN 1995, this percentage decreased to 9.7 percent. In 1993, 9 percent of mothers reported that a lack of a telephone stopped them from obtaining primary care for that infant. In 1995, this percentage decreased to 5.1 percent.

- In 1993, 93.6 percent of the mothers reported that they were satisfied or very satisfied with their infant's physician. In 1995, 95.8 percent of the mothers reported that they were satisfied or very satisfied with their infant's physician.

- In 1993, 10 percent of the births had a low weight. In 1995, this percentage decreased to 5 percent.

These findings are consistent with data reported in the RIte Care program, *Quarterly Report: January 1997 to March 1997,* on utilization of services and satisfaction with RIte Care. In reviewing the findings of the Infant Health Survey, it is important to keep in mind that before RIte Care, more than 50 percent of the inner city population received its primary care in hospital emergency rooms. Thus, **the patterns of where this population receives it primary care have changed while indicators of quality of care and satisfaction have improved.** A report of the study was forwarded to CMS when it was completed.

The State's initial clinical focused study on the Appropriateness of Neonatal Intensive Care Unit services was submitted to HCFA in August 1997. Findings of the second study, *Emergency Room Utilization*, were as follows:

- **Demographics** - Children (enrollees aged 17 and under) made up nearly 60 percent of the population of emergency room users; this is roughly equal to the percentage of children enrolled in RIte Care.

- **Emergency Room Utilization**

  - *Weekends and After-Hours* - Thirty-two percent of patient visits to the emergency room occurred on weekends. This does not differ significantly from the expected rate of 29 percent based on a normal distribution. There was no evidence that inappropriate emergency utilization increased after normal working hours.

  - *Appropriateness of Emergency Room Utilizations* - Fifty-two percent of emergency room utilization was either inappropriate or for an ambulatory care sensitive condition. Comparisons of utilization rates showed no significant difference among health plans.

- **Nurse and Physician Screening Rates** - Over 99 percent of enrollees in the sample were screened by a nurse and/or physician.

- **Emergency Room Coordination With PCPs and Health Plans** – Fifty-two percent of the time there was no documented contact between the ER and the health plans or PCP to the provision of services. ER coordination either during the visit or after discharge was documented in only 9 percent of the cases. A comparative analysis of the coordination rates by health plans did not indicate significant differences.

- **Health Plan Prior Authorization for Emergency Room Utilization** – Health plans prior-authorized less than one-third of the emergency room visits made by enrollees.

- **Emergency Room Services** – Of the 497 enrollees in the study who presented to the emergency room, 394 or 79 percent, received ER services. Sixty percent of the enrollees who inappropriately utilized the ER received services, while 89

percent of the patients who appropriately utilized the emergency room received services. These rates did not vary significantly by health plan. This area is undergoing additional analysis.

The most common services provided in the ER were laboratory, radiology, medication other than parental, monitoring and wound care.

- **Ambulatory-Care Sensitive Conditions –** Twenty-nine percent of enrollees had conditions that were ambulatory care sensitive. Although some of these cases may warrant utilization of the emergency room, further investigation is necessary to determine whether some percent of visits could have been avoided through more intensive management in an ambulatory setting.

It should also be noted that as an outgrowth of the State's monitoring activities, two major changes in the health plan contracts with the State were made:

- Establishment of an incentive-based performance system

- Requirement that the Health Plans undertake three (3) quality studies annually directed at the RIte Care population.

With respect to the former, Attachment B shows the *Performance Goals for the 2001 RIte Care Performance Goal Incentive Program*.

- Administration/Management
- Access
- Clinical Care

The attachment shows the health plan performance by each measure for 1999, 2000, and 2001 as well as the incentive payments made to each Health Plan in 2001. These incentives were as follows:

Neighborhood Health Plan of Rhode Island -$476,437
United Health Care of New England - $314,867
Coordinated Health Care/Blue Chip - $ 40,063

These respective payments reflect the State's approach of offering to Health Plans the opportunity to earn payments (incentives) over and above capitation payments for accomplishment of stated performance goals.

Other aspects of the measurement and demonstration of quality of care were shown in the earlier section on accomplishments of program goals.

During the procurement process, we cannot say definitively that we will proceed with them. We will keep HCFA apprised of our efforts.

3.4 ADEQUACY OF FINANCIAL MANAGEMENT

As Attachment D shows, RIte Care's revised appropriation and projected rate of expenditure for Fiscal year 2002 is $244,515,274. This demonstrates that the program is adequately financed for the current fiscal year. The Legislature has not yet acted on the budget for fiscal year 2003.

IV COMPLIANCE WITH BUDGET NEUTRALITY

As agreed to between the State and the Health Care Financing Administration for the period August 1, 1994, to July 31, 1995, all data included in the budget neutrality calculation refer to in-plan services for RIte Care *enrollees* only. Other expenses, such as methadone maintenance, dental, and mental health case management have been excluded from the fee-for-service equivalency benchmark.

As Attachment C shows, the aggregate expenditures for RIte Care from August 1, 1995, through July 31, 2001. This compares favorably with the aggregate budget neutrality cap for the same time period.

The State has been mindful of the limitations imposed by the budget neutrality caps since RIte Care's inception and has undertaken planning and policy making with these caps in mind. The State monitors the program against these caps to assure State compliance.

C. STATE NOTICE PROCEDURES

Since the inception of RIte Care, the State has taken seriously public and consumer involvement in the transition of Medicaid from fee for service to managed care. As it has considered each of the waivers and expansions of coverage, the Center for Child and Family Health (CCFH) has reviewed the options with the Consumer Advisory Committee (CAC), a group of consumers and advocates that meets monthly with MS agency staff. In certain instances, CCFH and the CAC have held meetings throughout the community to discuss the impact of proposed changes on consumer and provider communities.

The CAC responded unanimously and positively during discussions about the extension of the 1115 waiver. The state is participating in a number of public meetings throughout the state convened under the auspices of the HealthCare Organizing Project of Ocean State Action funded by the Robert Wood Johnson Foundation. The purpose of the meetings are to obtain feedback from local consumers about recommendations to improve RIte Care and RIte Share. In addition, the HealthCare Organizing Project has a statewide "hot" line that it has set up to accept information from persons wishing to comment on RIte Care. The HealthCare Organizing Project has distributed information cards to community-based agencies throughout the state encouraging people to call the "hot" line with questions and concerns. Public meetings have been held in Providence (January 11, 2002) and Newport (March 13, 2002). Additional meetings are planned for Woonsocket and Central Falls.

The meeting attendance in South Providence and Newport averaged 10-12 consumers. The topics of discussion were similar: access to and availability of dental services; concern about cost sharing initiated by the State in January; and some continuing confusion about the premium assistance program – RIte Share. The overall feedback was positive about RIte Care and access to the health care services covered under the contracts with the participating health plans.

In general, those present at the meetings indicated that as RIte Care members, they were accepted at participating providers and experienced no limitations on gaining access to the health care system.

RITE CARE UTILIZATION DATA
STANDARD AVAILABLE REPORTS
ATTACHMENT A

Population Description

RIte Care Population by Quarter: SFY 1995-2001; Jul-Sep 2001, Oct-Dec 2001. Program Total and Stratified by Health Plan.

RIte Care Female Population 15-44 by Quarter: SFY 1995-2001; Jul-Sep 2001, Oct-Dec 2001. Program Total and Stratified by Health Plan.

Live Births by Quarter: SFY 1995-2001; 1st Quarter SFY 2002. Program Total and Stratified by Health Plan.

Live Birth Rate per 1,000 Members 15-44 by Quarter: SFY 1995-2001; 1st Quarter SFY 2002. Program Total and Stratified by Health Plan.

Hospital Services

Inpatient Admissions by Quarter: SFY 1995-2001; 1st Quarter SFY 2002. Program Total and Stratified by Health Plan.

Inpatient Admission Rate per 1,000 Members by Quarter: SFY 1995-2001; 1st Quarter SFY 2002. Program Total and Stratified by Health Plan.

Total Inpatient Days by Quarter: SFY 1995-2001; 1st Quarter SFY 2002. Program Total and Stratified by Health Plan.

Total Inpatient Days per 1,000 Members by Quarter: SFY 1995-2001; 1st Quarter SFY 2002. Program Total and Stratified by Health Plan.

Average Length of Stay by Quarter: SFY 1995-2001; 1st Quarter SFY 2002. Program Total and Stratified by Health Plan.

Total In-Plan NICU Admissions by Quarter: SFY 1995-2001; 1st Quarter SFY 2002. Program Total and Stratified by Health Plan.

Total Out-of-Plan NICU Admissions by Quarter: SFY 1998-2001; 1st Quarter SFY 2002. Program Total and Stratified by Health Plan.

Total NICU Admissions (In-Plan and Out-of-Plan) by Quarter: SFY 1995-2001; 1st Quarter SFY 2002. Program Total and Stratified by Health Plan.

Total NICU (In-Plan and Out-of-Plan) Admissions Rate per 1,000 Live Births by Quarter: SFY 1995-2001; 1st Quarter SFY 2002. Program Total and Stratified by Health Plan.

Total NICU Days (In-Plan and Out-of-Plan) by Quarter: SFY 1995-2001; 1st Quarter SFY 2002. Program Total and Stratified by Health Plan.

Total NICU Days (In-Plan and Out-of-Plan) per 1,000 Live Births by Quarter: SFY 1995-2001; 1st Quarter SFY 2002. Program Total and Stratified by Health Plan.

Ambulatory Services

Emergency Department Visits by Quarter: SFY 1995-2001; 1st Quarter SFY 2002. Program Total and Stratified by Health Plan.

Emergency Department Visit Rate per 1,000 Members by Quarter: SFY 1995-2001; 1st Quarter SFY 2002. Program Total and Stratified by Health Plan.

Outpatient Physician Visits (PCP) by Quarter: SFY 1997-2001; 1st Quarter SFY 2002. Program Total and Stratified by Health Plan.

Outpatient Physician Visit (PCP) Rate per 1,000 Members by Quarter: SFY 1997-2001; 1st Quarter SFY 2002. Program Total and Stratified by Health Plan.

Outpatient Physician Visits (Specialist) by Quarter: SFY 1997-2001; 1st Quarter SFY 2002. Program Total and Stratified by Health Plan.

Outpatient Physician Visit (Specialist) Rate per 1,000 Members by Quarter: SFY 1997-2001; 1st Quarter SFY 2002. Program Total and Stratified by Health Plan.

Ancillary Services

Laboratory Services by Quarter: SFY 1999-2001; 1st Quarter SFY 2002. Program Total and Stratified by Health Plan.

Laboratory Service Rate per 1,000 Members by Quarter: SFY 1999-2001; 1st Quarter SFY 2002. Program Total and Stratified by Health Plan.

Radiology Services by Quarter: SFY 1999-2001; 1st Quarter SFY 2002. Program Total and Stratified by Health Plan.

Radiology Service Rate per 1,000 Members by Quarter: SFY 1999-2001; 1st Quarter SFY 2002. Program Total and Stratified by Health Plan.

PT/OT Services by Quarter: SFY 1997-2001; 1st Quarter SFY 2002. Program Total and Stratified by Health Plan.

PT/OT Service Rate per 1,000 Members by Quarter: SFY 1997-2001; 1st Quarter SFY 2002. Program Total and Stratified by Health Plan.

PERFORMANCE GOALS FOR THE 2001
RITE CARE PERFORMANCE GOAL INCENTIVE PROGRAM
ATTACHMENT B

I. ADMINISTRATION/MANAGEMENT

1. Temporary identification cards are distributed within ten (10) days of enrollment and permanent identification cards within forty-five (45) days of enrollment.

Standard: 98 percent
Reference Period: Calendar year 2000
Does not need to be RIte Care specific

Note: The goal is that cards are distributed within ten days. If the Health Plan only issues permanent cards and does not use temporary cards, permanent cards must be issued within 10 days. If temporary cards are used, both the ten day and the forty-five day standards must be met.

Performance Assessment

- Review of Policies and Procedures
- Detailed monthly reports with method to track time from enrollment to distribution of cards
- Actual performance as demonstrated in reports

2. Member handbooks are distributed within ten (10) business days of being notified of enrollment.

Standard: 98 Percent
Reference Period: Calendar year 2000
Does not need to be RIte Care specific

Performance Assessment

- Review of Policies and Procedures
- Detailed monthly reports with method to track time from enrollment to distribution of member handbooks
- Actual performance as demonstrated in reports

3. Members without primary card providers (PCP) at enrollment are assigned a PCP within twenty (20) days of enrollment, after being given opportunity to select one.
Standard: 95 Percent
Reference Period: Calendar year 2000
Must be RIte Care specific

Performance Assessment

Part I. Opportunity to select PCP

- Policies and Procedures
- Documentation of effort to contact and process PCP assignment

Part II. Assignment in cases where no selection is made

- Reports demonstrating days from enrollment to assignment
- Monthly performance against standard

4. Average speed to answer calls is thirty (30) seconds or less.

Standard 100 Percent
Reference Period: July 2000 - December 2000
Does not need to be RIte Care specific
Will apply to customer service line only

Performance Assessment

Information base and method for reporting must be demonstrated. Average speed to answer for each month is $\leq$ 30 Percent.

5. Call abandonment rate is five (5) percent or less.

Standard: 100 Percent
Reference Period: July 2000 - December 2000
Does not need to be RIte Care specific
Will apply to customer service line only

Performance Assessment

Information base and method for reporting must be demonstrated. Call abandonment rate for each month is $\leq$ 5 Percent.

6. Grievances and appeals are resolved within State statutory time frames.

Standard: 97 Percent
Reference Period: Calendar year 2000
Based on RIte Care standards

Performance Assessment

- Review Policies and Procedures for identifying and acting upon grievances and appeals

- Ensure that processes are in place to notify members of opportunities for grievances and appeals

- Review logs or other Health Plan mechanisms for tracking complaints, grievances and appeals (medical and other)

- If no grievances (or appeals) ability to demonstrate resolution of issue before its elevation to grievance or appeal level

- If grievances and appeals are present, percent resolved timely

7. Payment of "clean" claims is made within thirty (30) days

Standard: 95 Percent of claims paid within 30 days or receipt
Reference Period: July 2000- December 2000
Does not need to be RIte Care specific

Performance Assessment

- Claims reports which evidence methods to assess performance against standard. This will include tracking based on date of claim receipt, date processed and date of payment. Where different claim types are processed in separated queues they need to be separately identified and tracked.

- Monthly performance against standard.

8. Payment of claims is made for medical screening examinations in a hospital emergency room to determine if a medical emergency exists.

Standard: 100 Percent
Reference Period: Calendar year 2000
RIte Care specific

Performance Assessment

- The basis for review will be the claims processing history of hospitals emergency room bills. Standard is that there are zero denials for emergency room bills which are submitted for Health Plan eligible members.

9. Contractor notifies the Department of Human Services of any potential source of third-party liability within fifteen (15) days of such source becoming known to contractor.

Standard: 90 Percent
Reference Period: Calendar year 2000
RIte Care specific

Performance Assessments

- Review of Policies and Procedures regarding TPL
- Established method and reporting for internal review of TPL
- Timely and regular reports provided to Center for Child and Family Health

II. ACCESS PERFORMANCE GOALS

1. Members seeking treatment of an emergency medical condition are offered and receive services immediately.

Standard: 100 Percent
Reference year: Calendar year 2000
RIte Care specific

Performance Assessment

- Health Plan's written materials for members provide clear direction for obtaining care in the case of emergency

  - Member handbook
  - Member ID card

- Additional member education material on emergency, e.g. newsletter, other mailing

- Provider contract, manual and provider education regarding emergency policy

- Health Plan has demonstrable practice showing that it identifies and tracks on a current basis all emergency care visits to emergency room or requests for assistance in obtaining care

2. Member seeking treatment of an urgent medical condition receives services within twenty-four (24)

Standard: 95 Percent
Reference year: Calendar 2000
RIte Care specific

Performance Assessment

- Health Plan has established policy, procedure and method(s) to identify members in need of treatment of an urgent medical condition.

- Provider contract, manual and provider education regarding urgent care policy

- For cases where need to treatment for an urgent medical condition is identified, demonstration of steps taken to ensure access to treatment (e.g. review and follow up of complaints, provider surveys of urgent care appointment availability, assistance in making appointment, transportation arrangements, expedited review and/or authorization procedures)

3. Members seeking treatment of a non-emergent, non-urgent behavioral health condition receive services within (5) business days.

Standard: 75 Percent
Reference year: Calendar year 2000
RIte Care Specific

Performance Assessment

- Review Health Plan's method for tracking this standard of care and documenting performance

- Review reports for selected periods. Determined performance level

4. New adult members receive a first visit with a PCP within ninety-days of enrollment.

Standard: 50 Percent
Reference Period: Calendar year 2000
RIte Care specific

Performance Assessment

Assessment is based on analysis of the encounter data edited and loaded no later than April 16, 2001.

Measure:

Denominator is the number of adults (18 years +) new to RIte Care (and therefore the Health Plan) between January 1, 2000 and November 15, 2000. Note: Persons eligible for RIte Care by virtue of pregnancy will be removed from the denominator

Numerator is the number of those adults with a visit to PCP within 42 days of enrollment in RIte Care.

Note: PCP includes Pediatrician, Internist, OB/GYN, nurse practitioner, family practice, GP, D.O., nurse midwife, physician assistant.

5. New members under age 18 receive a first visit with a PCP within ninety-days of enrollment.

Standard: 65 Percent
Reference Period: Calendar year 2000
RIte Care specific

Performance Assessment

Assessment is based on analysis of the encounter data edited and loaded no later than April 16, 2001.

Measure:

Denominator is the number of children (under age 18) new to RIte Care (and therefore the Health Plan) between January 1, 2000 and November 15, 2000.

Numerator is the number of those children with a visit to PCP within 31 days of enrollment in RIte Care.

Note: PCP includes Pediatrician, Internist, OB/GYN, nurse practitioner, family practice, GP, D.O., nurse midwife, physician assistant.

III. CLINICAL CARE PERFORMANCE GOALS

1. The percentage of children who turned two years old during the reporting year, who were continuously enrolled for 12 months immediately preceding their second birthday (including members who have had no more than one gap of enrollment of up to 45 days during the 12 months immediately preceding their second birthday), and who have received appropriate immunizations shall be at, or exceed, standard.

Standard: 85 Percent
Reference period: Calendar Year 2000
RIte Care specific

Performance Assessment

Assessment is based on analysis of the encounter data edited and loaded by EDS no later than April 16, 2001.

Measure:

Denominator will be all children who turned two years old during the reporting year, who were continuously enrolled for 12 months immediately preceding their second birthday (including members who have had no more than on gap of enrollment of up to 45 days during the 12 months immediately preceding their second birthday).

Numerator Children with the age appropriate number and type of immunizations during the second year of life (DTAP or DTP, Hib, polio, MMR).

2. Members between 6 - 20 years are provided EPSDT age-appropriate screenings.

Standard: 85 Percent
Reference period: Calendar Year 2000
RIte Care specific

Performance Assessment

Assessment is based on analysis of the encounter data edited and loaded by EDS no later than April 16, 2001.

Measure: This measure is based on the requirement for EPSDT screenings.

Age groupings for the calculation are 6 - 20 years of age

Denominator: Members under age twenty-one who have been continuously enrolled for twelve months with no break in enrollment greater than 45 days.

Numerator: The number of eligibles receiving a screening service by a primary care provider during the calendar year.

3. Pregnant members receive adequate or adequate-plus prenatal care services as measured by the Kotelchuk Index.

Standard: 85 Percent
Reference Period: Calendar year 2000
RIte Care specific

Performance Assessment

Measure: Assessment is based on receipt of adequate or adequate-plus prenatal care as measured by receipt of at least the expected number of prenatal care visits. The standard is 85 percent. If 85 percent of women receive 100 percent of more of the expected number of prenatal care visits, the standard is reached.

Denominator: Total number of women giving birth during the reference period. For each woman, the expected number of prenatal visits is calculated based on the date of the first prenatal visit. The expected number of visits is based on the Kotelchuk index.

Numerator: Total number of women for whom the actual number of prenatal visits matches or exceeds the expected number of visits.

4. Average length of maternity stay is two (2) days for a vaginal delivery and four (4) days for a Caesarian delivery.

Each indicator is measured separately
Standard: 100 Percent
Reference period: Calendar year 2000
RIte Care specific

Performance Assessment

Assessment is based on analysis of the encounter data edited and loaded no later than April 16, 2001.

Denominator is total number of admissions for labor and delivery of each type (vaginal Caesarian).

Numerator: Total days for each delivery type with calculation based on day of admission and day of discharge.

5. Members who reach 18 months during the reference period who have had an initial lead blood screen within the preceding nine months.

Standard: 85 Percent
Reference Period: Calendar year 2000
RIte Care specific

Performance Assessment

Assessment is based on analysis of the encounter data edited and loaded by EDS no later than April 16, 2001.

Denominator: All children who reach 18 months of age during the reference period and who have been enrolled with the Health Plan at least 31 days

Numerator: Of the children identified in the denominator, all those with an initial lead blood screen during the preceding nine months.

6a. Female enrollees aged 16 to 20 continuously enrolled for a year have one or more PAP tests during the past year.

Standard: 40 Percent
Reference Period: Calendar year 2000
RIte Care specific

Performance Assessment

Assessment is based on analysis of the encounter data edited and loaded by EDS no later than April 16, 2001.

Denominator: All female members continuously enrolled for one year who achieve their sixteenth birthday during the reference year but have not achieved their twenty-first birthday.

Numerator: All members in the denominator who have one or more PAP tests during the reference period.

6b. Female enrollees aged 21 to 64 continuously enrolled for a year have one or more PAP tests within the past three years.

Standard: 80 Percent
Reference Period: Calendar year 2000
RIte Care specific

Performance Assessment

Assessment is based on analysis of the encounter data edited and loaded by EDS no later than April 16, 2001.

Denominator: All female members continuously enrolled for one year who have achieved their twenty-first birthday during the reference period but did not achieve their sixty-fifth birthday.

Numerator: All members in the denominator who have one or more PAP tests during the reference period. Note: The calculation is based on a one year period while the standard is based on three years. To adjust for this, the numerator derived from the one year period will be multiplied by three to assign a three year rate.

PMPM RATE INCREASE (BASE VS. PROJECTED)
ATTACHMENT C

Time Period	PMPM Base	% increase (annualized)	PMPM Projected	% increase (annualized)
8/94 - 7/95	$125.74		$117.04	
8/95 - 7/01	$145.71	4.0%	$143.48	3.8%
8/01 - 7/02	$168.35	3.9%	$173.41	4%
8/02 - 7-03	$175.09	4.0%	$181.37	5%
8/03 - 7-04	$182.09	4.0%	$193.84	7%
8/04 - 7-05	$189.38	4.0%	$204.68	6%
8/05 - 7-06	$196.95	4.0%	$216.58	6%
8/06 - 7-07	$204.83	4.0%	$229.19	6%

STATE OF RHODE ISLAND APPROPRIATION
ATTACHMENT D

RITE CARE PROGRAM SFY 2002

	Member Months		Premium
RIte Care - Core Population	1,110,174.8		$169,902,801
RIte Care - Waiver Population	222,772.4		19,468,013
RIte Care - State Only	51,840.00		4,432,436
Subtotal	**1,384,787.2**		**$193,803,250**
FQHC Supplemental Payment			$5,500,000
Subtotal			$199,303,250
Dental			$7,473,343
Retro and Other FFS*			$37,738,681
Subtotal			$45,212,024
Grand Total			**$244,515,274**

*Includes NICU and all other fee-for-service